1992

Bleazard v. Department of Health : Unknown

Utah Court of Appeals

J. Stephen Mikita, Douglas W. Springmeyer; attorney for respondent.
David B. Erickson, David J. Hardy; attorneys for petitioner.

LAW OFFICES OF
KIRTON, McCONKIE & POELMAN
A PROFESSIONAL CORPORATION
1800 EAGLE GATE TOWER
60 EAST SOUTH TEMPLE
SALT LAKE CITY, UTAH 84111-1004
TELEPHONE (801) 328-3600
FAX (801) 321-4893
DAVID J. HARDY

June 17, 1993

Court of Appeals
230 South 500 East #400
Salt Lake City, UT 84102

Re: ***Bleazard v. Utah Department of Health***
Case No. 920787

To the Court:

Pursuant to your request that we provide references cited in the various Briefs to this case, enclosed please eight copies of the following:

Cited in Brief of Petitioner:

20 C.F.R. § 416.1167 (1992)
42 C.F.R. §§ 435.700-435.740 (1992)
42 C.F.R. § 435.800-852 (1992)(including 435.821 & 435.831)
45 C.F.R., Part 211
Assistance Payment Administration Manual, Volume III-F, Section 305-2
Assistant Payment Administration Manual, Volume III-F, Section 305-3

Cited in Brief of Respondent:

20 C.F.R. § 416.1201 (1992)
20 C.F.R. § 416.1210 (1992)
S. Rep. # 404, 89th Cong., 1st Sess., as contained in 1965 U.S. Code Congressional and Administrative News, 2014-2017.

Cited in Reply Brief of Petitioner:

Assistance Payment Administration Manual, Volume III-F, Section 215-1.

Several of the requested sections are contained in the attached references.

I have not included House of Representatives Report No. 213 from the First Session of the 89th Congress. I could not obtain a copy of this report, but I have contacted Mr. Mikita's office and asked that they submit a copy to the court.

Additionally, I note your request that we supply Volumes III-F and III-M of the Assistance Payments Administration Manual in their entirety. In response, please note that each of the volumes of the Assistance Payments Administration Manual is several inches thick. We will defer providing a copy until you have determined that they are critical to the court. All relevant sections from those manuals have been cited by the parties.

As to Public Law No. 89-97, I note that this takes up about 140 pages in the Statutes at Large. Instead of us providing a copy, please refer to 42 U.S.C. §§ 1396 et seq.

Please call me if you have further requests.

Very truly yours,

KIRTON, McCONKIE & POELMAN

David J. Hardy

DJH:jsg
Enclosure

cc: J. Stephen Mikita

Federal benefit rate for an individual) and $504 for Mrs Hart and the two children ($168 or one-half the Federal benefit rate for an eligible individual for each), a total of $840 The allocations ($840) are deducted from the total $1,500 income which leaves $660 This amount must be deemed independently to Mr and Mrs Smith Mr and Mrs Smith would qualify for SSI benefits as a couple in the amount of $504 if no income had been deemed to them The $1,320 ($660 each to Mr and Mrs Smith) deemed income is unearned income to Mr and Mrs Smith and is subject to the $20 general income exclusion leaving $1,300 This exceeds the couple s rate of $504 so Mr and Mrs Smith are ineligible for SSI benefits

Example 3 Mr Bert and Mr Davis are aliens sponsored by their sister Mrs Jean, who has earned income of $800 She also receives $250 as survivors benefits for her two minor children We do not consider the $250 survivors benefits to be Mrs Jean s income because it is the children's income We exclude $336 for Mrs Jean (the Federal benefit rate for an individual) plus $336 ($168, one-half the Federal benefit rate for an eligible individual for each child), a total of $672 We subtract the $672 from Mrs Jean s income of $800, which leaves $128 to be deemed to Mr Bert and Mr Davis Each of the brothers is liable for rent in the boarding house (a commercial establishment) where they live Each lives in his own household, receives no in-kind support and maintenance, and is eligible for the Federal benefit rate of $336 The $128 deemed income is deemed both to Mr Bert and to Mr Davis As a result, each has countable income of $108 ($128 minus the $20 general income exclusion) This is less than $336, the Federal benefit rate for an individual, so that both are eligible for SSI We use their income in a prior month to determine their benefit payments

Example 4 The same situation applies as in example 3 except that one of Mrs Jean s children is disabled and eligible for SSI benefits The eligibility of the disabled child does not affect the amount of income deemed to Mr Bert and Mr Davis since the sponsor to alien and parent-to-child rules are applied independently The child's countable income is computed under the rules in § 416 1165

[52 FR 8887, Mar 20, 1987]

§ 416.1167 Temporary absences and deeming rules.

(a) *General.* A temporary absence, for the purpose of deeming, occurs when you or your ineligible spouse or parent or an ineligible child leaves the household but intends to, and does, return in the same month or the month immediately following. If the absence is temporary, we continue to consider the person a member of the household.

(b) *Child away at school.* If you are an eligible child who is away at school but comes home on some weekends or lengthy holidays and if you are subject to the control of your parents, we consider you temporarily absent from your parents' household. However, if you are not subject to parental control, we do not consider your absence temporary and we do not deem parental income (or resources) to you. Being subject to parental control affects deeming to you only if you are away at school.

[50 FR 48579, Nov 26, 1985]

§ 416.1168 How we deem income to you from your essential person.

(a) *Essential person's income.* If you have an essential person, we deem all of that person s income (except any not counted because of other Federal statutes as described in § 416 1161(b)) to be your own unearned income. If your essential person is also your ineligible spouse, or if you are a child whose essential person is your ineligible parent, we apply the essential person deeming rules in this section. See § 416.1169 for the rules that apply when an ineligible spouse or parent ceases to be your essential person.

(b) *Determining your eligibility for an SSI benefit.* We apply the exclusions to which you are entitled under §§ 416.1112 and 416.1124 to your earned income and to your unearned income which includes any income deemed from your essential person. After combining the remaining amounts of countable income, we compare the total with the Federal benefit rate for a qualified individual (see § 416.413) to determine whether you are eligible for an SSI benefit.

(c) *Determining your SSI benefit amount.* We determine your SSI benefit amount in the same way that we determine your eligibility. However, in following the procedure in paragraphs (a) and (b) of this section we use your essential person's income that we deemed to you in the second month

Subpart H—Financial Requirements for the Categorically Needy

§ 435.700 Scope.

This subpart prescribes financial requirements for determining the eligibility of categorically needy individuals under subparts B and C of this part. The requirements apply only to individuals who are not receiving AFDC, SSI, or an optional State supplement. The financial eligibility requirements of AFDC, SSI, or the State supplement apply to individuals receiving those payments. This subpart also prescribes requirements for applying an institutionalized recipient's income to cost of care.

Financial Requirements Applicable to Optional Groups: Families and Children

§ 435.711 General requirements.

In determining eligibility for families and children, a Medicaid agency must apply the financial eligibility requirements of the State's AFDC plan.

§ 435.712 Financial responsibility of spouses and parents.

(a) For families and children, the agency must consider income and resources of spouses or parents as available to the individual whether or not they are actually contributed, if they live in the same household. For this purpose, "parent" includes a stepparent if he is equally liable with the natural parent for the support of children under State law of general applicability.

(b) If the spouse or parent does not live with the individual, the agency must consider only income and resources that are actually contributed to the individual from a parent or spouse as available to him.

(c) Even if State law confers adult status below age 21, the agency must consider parental income and resources as available to a child, if he is living with the parent, until he becomes 21.

Financial Eligibility Requirements Applicable to Optional Groups: The Aged, Blind, and Disabled in States Covering Individuals Receiving SSI

§ 435.721 General requirements.

(a) This section applies when an agency provides Medicaid to—

(1) All SSI recipients or to all SSI recipients and to State supplement recipients; and

(2) One or more of the optional coverage groups specified in §§ 435.210 (eligible for but not receiving cash), 435.211 and 435.231 (institutionalized individuals).

(b) If the agency, under § 435.120, provides Medicaid to SSI recipients but not to optional State supplement recipients, it must use the SSI financial eligibility requirements to determine Medicaid eligibility of aged, blind, and disabled individuals under the optional provisions of §§ 435.210, 435.211, and 435.231. However, under § 435.231, it may use a higher income standard than SSI to determine eligibility for institutionalized individuals.

(c) If the agency provides Medicaid to SSI recipients and, under § 435.230, to individuals who are not receiving SSI but are receiving optional State supplements, the agency must use the following criteria to determine Medicaid eligibility under the optional provisions of §§ 435.210, 435.211, and 435.231 for aged, blind, and disabled individuals:

(1) The agency must use the SSI financial eligibility requirements for individuals who would be eligible for SSI but would not be eligible for an optional State supplement.

(2) The agency must use the supplement program's financial eligibility requirements for individuals who would be eligible for an optional State supplement. However, the agency may use a higher income standard than SSI or the State supplement program to determine eligibility of institutionalized individuals under § 435.231.

(d) In determining eligibility under paragraph (b) or (c) of this section, the agency must use the SSI deductions from income and resources and budgeting methods set forth in 20 CFR part 416, unless greater deductions from income and higher income standards are used in an optional State supplement program that meets the requirements of § 435.230.

§ 435.722 Individuals in institutions who are eligible under a special income level.

(a) If an agency, under § 435.231, provides Medicaid to individuals in medical institutions and intermediate care facilities who would not be eligible for SSI or State supplements if they were not institutionalized, the agency must use income standards based on the greater need for financial assistance that the individuals would have if they were not in the institution. The standards may vary by the level of institutional care needed by the individual (hospital, skilled nursing, or intermediate level care), or by other factors related to individual needs. (See § 435.1005 for FFP limits on income standards established under this section.)

(b) In determining the eligibility of individuals under the income standards established under this section, the agency must not take into account income that would be disregarded in determining eligibility for SSI or for an optional State supplement.

(c) The agency must apply the income standards established under this section effective with the first day of a period of not less than 30 consecutive days of institutionalization.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 53 FR 3595, Feb. 8, 1988]

§ 435.723 Financial responsibility of spouses.

(a) If the agency provides Medicaid to SSI recipients, it must meet the requirements of this section in determining eligibility of aged, blind, and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.

(b) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the time periods specified below. After the appropriate time period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(1) If spouses cease to live together because of the institutionalization of one spouse—

(i) The agency must consider their income as available to each other through the month in which they cease to live together. Mutual consideration of income ceases with the month after the month in which separation occurs.

(ii) The agency must consider their resources as available to each other for the month during which they cease to live together and the six months following that month.

(2) If spouses cease to live together for any reason other than institutionalization, the agency must consider their income and resources as available to each other for the month during which they cease to live together and the six months following that month. If the mutual consideration of income and resources causes the individuals to lose eligibility as a couple, the agency will determine if an individual is eligible in accordance with paragraph (d) of this section.

(d) If only one spouse in a couple applies or is eligible, or both spouses apply and are not eligible as a couple, and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month in which they cease to live together.

[43 FR 45204, Sept. 29, 1978, as amended at 48 FR 39629, Sept. 1, 1983]

§ 435.724 Financial responsibility of parents for blind or disabled children.

(a) If the agency provides Medicaid to SSI recipients, it must meet the requirements of this section in determining eligibility of blind and disabled children under the optional coverage of §§ 435.210, 435.211, 435.225, and 435.231.

(b) If the child is under age 18 and is living in the same household with a parent or spouse of a parent, the agency must consider the parent's or spouse's income and resources available to the child, whether or not they are actually contributed. This rule also applies to a child under 21 living in the same household, if he is regularly attending a school, college, or university or is receiving technical training designed to prepare him for gainful employment.

(c) After the month in which the child ceases to live with a parent or spouse of a parent, the agency must consider only the income and resources of that parent or spouse that are actually contributed to the child. This rule applies even if the child returns to the household for periodic visits.

(d) Under the option provided by § 435.225, the income and resources of the parent or the parent's spouse are not considered available to the disabled child receiving care at home.

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17937, Mar. 23, 1979; 55 FR 48609, Nov. 21, 1990]

§ 435.725 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities.

(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under § 435.812, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991]

§ 435.726 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based

services provided to an individual specified in paragraph (b) of this section by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48539, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992]

Financial Eligibility for the Aged, Blind, and Disabled in States Using More Restrictive Requirements Than SSI

§ 435.731 General requirements for determining income eligibility in States using more restrictive requirements than SSI.

Requirements applicable to all individuals. If the agency, under § 435.121 uses any requirement for aged, blind or disabled individuals more restrictive than an eligibility requirement under SSI, the agency must determine income in accordance with § 435.732 with respect to any category for which more restrictive requirements are imposed. The agency must use the procedures in § 435.732 regardless of the type of restrictive eligibility factor imposed.

[45 FR 24884, Apr. 11, 1980]

§ 435.732 Procedures for determining income eligibility.

The agency must determine income eligibility of individuals in the categories specified in § 435.731 in the following manner:

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income:

(1) Any SSI benefit the individual receives.

(2) Any optional State supplement the individual receives.

(3) Increases in OASDI that are deducted under §§ 435.134 and 435.135(c) for individuals specified in those sections.

(4) Other deductions from income applied under the Medicaid plan.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard established under § 435.121 the individual is eligible for Medicaid.

(c) *Deduction of incurred medical expenses.* (1) If countable income exceeds the income standard, the agency must deduct from income expenses incurred by the individual or financially responsible relatives for necessary medical and remedial services that are recognized under State law and are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles or coinsurance charges, and copayments or deductibles imposed under § 447.51 or § 447.53 of this subchapter.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income.

(d) *Eligibility based on incurred medical expenses.* If, after incurred medical expenses are deducted, remaining income is equal to or less than the income standard, the individual is eligible for Medicaid.

[45 FR 24884, Apr. 11, 1980]

§ 435.733 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities:

(1) Individuals receiving cash assistance under AFDC who are eligible for Medicaid under § 435.110 and individuals eligible under § 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.

(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121, or

(ii) The medically needy standard for an individual;

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under subpart I of this part for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance permiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses that may be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24884, Apr. 11, 1980, as amended at 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb 8 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991]

§ 435.734 Financial responsibility of spouses and parents.

(a) In determining Medicaid eligibility of an aged, blind, or disabled individual under requirements more restrictive than those used under SSI, the agency must consider the income and resources of spouses and parents as available to the individual in the manner specified in §§ 435.723 and 435.724 or in a more extensive manner, but not more extensive than the requirements in effect under the Medicaid plan on January 1, 1972.

(b) The agency may consider deemed income and resources of spouses and parents as unavailable to an individual when:

(1) The spouse, or parents (or spouse of a parent) are living in the same household as the individual; and

(2) The Secretary determines under authority in section 1614(f) of the Act, 20 CFR 416.1161a, 426.1204a and notifies the agency that deeming of income and resources under the usual SSI deeming rules is inequitable.

[48 FR 39629, Sept. 1, 1983, as amended at 49 FR 5747, Feb. 15, 1984]

§ 435.735 Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217, and are eligible for home and community-based services furnished under a waiver of State plan requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121, or

(ii) The medically needy standard for an individual.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The more restrictive income standard established under § 435.121 or

(ii) The medically needy standard for an individual.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home, and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under Subpart I of this part for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48540, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992]

[1] 159 O—92——6

FINANCIAL REQUIREMENTS APPLICABLE TO INDIVIDUALS UNDER PROTECTED COVERAGE PROVISIONS

§ 435.740 Protected Medicaid eligibility for individuals eligible in December 1973.

In determining whether individuals continue to meet the income requirements used in December 1973, for purposes of determining eligibility under §§ 435.131, 435.132, and 435.133, the agency must deduct increased OASDI payments to the same extent that these deductions were in effect in December 1973. These deductions are required by section 306 of the Social Security Amendments of 1972 (Pub. L. 92-603) and section 1007 of Pub. L. 91-172 (enacted Dec. 30, 1969), modified by section 304 of Pub. L. 92-603.

Subpart I—Financial Requirements for the Medically Needy

§ 435.800 Scope.

This subpart prescribes financial requirements for determining the eligibility of medically needy individuals under subpart D of this part.

MEDICALLY NEEDY INCOME STANDARDS

§ 435.811 Medically needy income standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a covered group;

(c) For FFP purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size (see § 435.1007); and

(d) Reasonable (see § 435.812).

[46 FR 47987, Sept. 30, 1981]

§ 435.812 Medically needy income standards: Reasonableness.

(a) The agency must use a medically needy income standard that is reasonable.

(b) The following medically needy income standards are presumed to be reasonable:

(1) The agency provides one medically needy income standard for all covered medically needy groups. Except as provided in paragraphs (c) and (d) of this section, the standard must at least equal the highest income or payment standard used to determine eligibility in the cash assistance programs (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to the covered medically needy groups.

(2) The agency provides a different medically needy income standard for each covered medically needy group. Except as provided in paragraphs (c) and (d) of this section, the standard for each covered group must at least equal the income or payment standard used to determine eligibility in the cash assistance program (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to that covered medically needy group.

(c) The agency may use a lower medically needy income standard than the standards specified in paragraph (b) of this section if—

(1) The income standard used under paragraph (b) of this section exceeds the maximum dollar amount of income allowed for purposes of FFP under § 435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

(d) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use an income standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy income standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(e) If the agency uses a medically needy income standard not specified in paragraphs (b) through (d) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

[46 FR 47987, Sept. 30, 1981]

§ 435.814 Medically needy income standards: State plan requirements.

(a) The State plan must specify the income standard for each covered medically needy group.

(b) If the agency uses an income standard that is not presumed to be reasonable under § 435.812, the State plan must describe that standard.

[46 FR 47987, Sept. 30, 1981]

FINANCIAL RESPONSIBILITY OF RELATIVES

§ 435.821 Financial responsibility of relatives: Individuals under age 21 and caretaker relatives.

(a) The agency must meet the requirements of this section in determining eligibility—

(1) Under § 435.308 of medically needy individuals under age 21; and

(2) Under § 435.310 of medically needy caretaker relatives.

(b) The agency must consider the parent's or spouse's income and resources as available if they are actually contributed to the individual.

(c) The agency may consider income and resources of spouses or parents as available to the individual even if they are not actually contributed to the individual.

[46 FR 47988, Sept. 30, 1981; 46 FR 54743, Nov. 4, 1981]

§ 435.822 Financial responsibility of relatives of aged, blind, or disabled individuals in States using SSI eligibility requirements.

(a) The agency must meet the requirements of this section in determining eligibility—

(1) Under § 435.320 of medically needy aged individuals;

(2) Under § 435.322 of medically needy blind individuals; and

(3) Under § 435.324 of medically needy disabled individuals.

(b) For aged, blind, or disabled individuals with spouses, the agency—

(1) Must consider income and resources as available if they are actually contributed by one spouse to another; and

(2) May consider income and resources of spouses as available to each other even if they are not actually contributed.

(c) For blind or disabled individuals under age 21—

(1) The agency must consider the parent's or spouse's income and resources as available if they are actually contributed to the individual; and

(2) The agency may consider the parent's or spouse's income and resources as available even if they are not actually contributed.

[46 FR 47988, Sept. 30, 1981; 46 FR 54743, Nov. 4, 1981]

§ 435.823 Financial responsibility of relatives of aged, blind, or disabled individuals in States using more restrictive requirements than SSI.

(a) The agency must meet the requirements of this section in determining eligibility under § 435.330 of medically needy aged, blind, and disabled individuals.

(b) For aged, blind, or disabled individuals with spouses, the agency—

(1) Must consider income and resources as available if they are actually contributed by one spouse to the other; and

(2) May consider income and resources of spouses as available to each other even if they are not actually contributed.

(c) For blind or disabled individuals under age 21, the agency—

(1) Must consider the parent's or spouse's income and resources as available if they are actually contributed to the individual; and

(2) May consider the parent's or spouse's income and resources as available even if they are not actually contributed.

[46 FR 47988, Sept. 30, 1981]

MEDICALLY NEEDY INCOME ELIGIBILITY

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective

period of not more than 6 months to compute income.

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determining eligibility, under § 435.121, of the categorically needy.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under § 435.814, the individual or family is eligible for Medicaid.

(c) *Deduction of incurred medical expenses.* (1) If countable income exceeds the income standard, the agency must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges, incurred by the individual or family or financially responsible relatives, including enrollment fees, copayments, or deductibles imposed under § 447.51 or § 447.53 of this subchapter.

(ii) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan.

(iii) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c)(1) (i) and (ii) of this section.

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual is eligible for Medicaid.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24886, Apr. 11, 1980; 46 FR 42067, Aug. 19, 1981; 46 FR 47988, Sept. 30, 1981]

§ 435.832 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or diability.

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the highest medically needy income standards for one person established under § 435.814.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's approved AFDC plan.

(B) The standards used to determine eligibility under the State's Medicaid plan, as provided for in § 435.814.

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance permiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24886, Apr. 11, 1980, as amended at 46 FR 47988, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb. 8, 1988; 53 FR 5344, Feb. 23, 1988; 56 FR 8850, 8854, Mar. 1, 1991]

MEDICALLY NEEDY RESOURCE STANDARDS

§ 435.840 Medically needy resource standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a resource standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a group; and

(c) Reasonable. (See § 435.841)

[46 FR 47988, Sept. 30, 1981; 46 FR 54734, Nov. 11, 1981]

§ 435.841 Medically needy resource standards: Reasonableness.

(a) The agency must use a medically needy resource standard that is reasonable, according to the provisions of this section.

(b) The following medically needy resource standards are presumed to be reasonable:

(1) The agency provides one medically needy resource standard for all covered medically needy groups. Except as provided in paragraph (c) of this section, the standard must at least equal the highest resource standard used to determine eligibility in the cash assistance programs related to the covered medically needy groups.

(2) The agency provides a different medically needy resource standard for each covered medically needy group. Except as provided in paragraph (c) of this section, the standard for each covered group must at least equal the highest resource standard used to determine eligibility in the cash assistance program related to that covered medically needy group.

(c) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use a resource standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy resource standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(d) If the agency uses a medically needy resource standard not specified in paragraphs (b) and (c) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

[46 FR 47988, Sept. 30, 1981; 46 FR 54743, Nov. 11, 1981]

§ 435.843 Medically needy resource standards: State plan requirements.

(a) The State plan must specify the resource standard for each covered medically needy group.

(b) If the agency uses a resource standard that is not presumed to be reasonable under § 435.841, the State plan must describe that standard.

[46 FR 47989, Sept. 30, 1981]

DETERMINING ELIGIBILITY ON THE BASIS OF RESOURCES

§ 435.845 Medically needy resource eligibility.

To determine eligibility on the basis of resources for medically needy individuals, the agency must—

(a) Consider only the individual's resources and those that are considered available to him under the financial responsibility requirements for relatives in § 435.821, § 435.822, or § 435.823;

(b) Consider only resources available during the period for which income is computed under § 435.831(a);

(c) For individuals under age 21 and caretaker relatives, deduct the value of resources that would be deducted in determining eligibility under the State's AFDC plan;

(d) For aged, blind, or disabled individuals in States covering all SSI recipients, deduct the value of resources that would be deducted in determining eligibility under SSI;

(e)(1) For aged, blind, or disabled individuals in States using requirements more restrictive than SSI, deduct the value of resources in an amount no more restrictive than those deducted under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI.

(2) However, the amounts specified in paragraph (e)(1) of this section must be the same as those that would be deducted in determining, under § 435.121, the eligibility of the categorically needy; and

(f) Apply the resource standards established under § 435.843.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24886, Apr. 11, 1980; 46 FR 47989, Sept. 30, 1981]

TREATMENT OF INCOME AND RESOURCES

§ 435.850 Treatment of income and resources: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a methodology for the treatment of income and resources that is—

(a) Uniform for all individuals in a covered group; and

(b) Reasonable (see § 435.851).

[46 FR 47989, Sept. 30, 1981]

§ 435.851 Treatment of income and resources: Reasonableness.

(a) The agency must use a methodology for the treatment of income and resources, to determine eligibility of the medically needy, that is reasonable.

(b) The methodology used to determine eligibility of individuals in the cash assistance program related to the covered medically needy group is presumed to be reasonable.

(c) If the agency provides Medicaid for the aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI, the methodology for the treatment of income and resources of those aged, blind, or disabled individuals under the State's plan on January 1, 1972, is presumed to be reasonable.

(d) If the agency uses a methodology not described in paragraphs (b) and (c) of this section—

(1) The methodology is not presumed to be reasonable; and

(2) HCFA must approve that methodology.

[46 FR 47989, Sept. 30, 1981]

§ 435.852 Treatment of income and resources: State plan requirements.

(a) The State's plan must specify the methodology used to treat the income and resources for each covered medically needy group.

(b) If the agency uses a methodology that is not presumed to be reasonable under § 435.851, the State plan must describe that methodology.

[46 FR 47989, Sept. 30, 1981]

Subpart J—Eligibility in the States and District of Columbia

SOURCE: 44 FR 17937, Mar. 23, 1979, unless otherwise noted.

§ 435.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

GENERAL METHODS OF ADMINISTRATION

§ 435.902 Consistency with objectives and statutes.

The Medicaid agency's standards and methods for determining eligibility must be consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and all other relevant provisions of Federal and State laws.

§ 435.903 Simplicity of administration.

The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the

(3) *Date of Application* is the date on which the action described in paragraph (b)(2) of this section occurs.

(4) *Redetermination* is a review of factors affecting AFDC eligibility and payment amount; e.g. continued absence, income (including child and spousal support), etc.

(5) *Assistance Unit* is the group of individuals whose income, resources and needs are considered as a unit for purposes of determining eligibility and the amount of payment.

[48 FR 28407, June 21, 1983 as amended at 49 FR 35599, Sept. 10, 1984; 51 FR 7217, Feb. 28, 1986; 51 FR 9203, Mar. 18, 1986; 52 FR 48689, Dec. 24, 1987; 53 FR 30433, Aug. 12, 1988; 57 FR 30157, July 8, 1992]

PART 211—CARE AND TREATMENT OF MENTALLY ILL NATIONALS OF THE UNITED STATES, RETURNED FROM FOREIGN COUNTRIES

Sec.

AUTHORITY: Secs. 1-11, 74 Stat. 308-310; 24 U.S.C. 321-329.

SOURCE: 39 FR 26546, July 19, 1974, unless otherwise noted.

§ 211.1 General definitions.

When used in this part:

(a) *Act* means Pub. L. 86-571, approved July 5, 1960, 74 Stat. 308, entitled "An Act to provide for the hospitalization, at Saint Elizabeths Hospital in the District of Columbia or elsewhere, of certain nationals of the United States adjudged insane or otherwise found mentally ill in foreign countries, and for other purposes";

(b) The term *Secretary* means the Secretary of Health and Human Services;

(c) The term *Department* means the Department of Health and Human Services;

(d) The term *Administrator* means the Administrator, Family Support Administration, Department of Health and Human Services;

(e) The term *eligible person* means an individual with respect to whom the certificates referred to in § 211.3 are furnished to the Administrator in connection with the reception of an individual arriving from a foreign country;

(f) The term *Public Health Service* means the Public Health Service in the Department of Health and Human Services;

(g) The term *agency* means an appropriate State or local public or nonprofit agency with which the Administrator has entered into arrangements for the provision of care, treatment, and assistance pursuant to the Act;

(h) The term *State* includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

(i) The term *residence* means residence as determined under the applicable law or regulations of a State or political subdivision for the purpose of determining the eligibility of an individual for hospitalization in a public mental hospital;

(j) The term *legal guardian* means a guardian, appointed by a court, whose powers, duties, and responsibilities include the powers, duties, and responsibilities of guardianship of the person.

[39 FR 26546, July 19, 1974, as amended at 53 FR 36580, Sept. 21, 1988]

§ 211.2 General.

The Administrator shall make suitable arrangements with agencies to the end that any eligible person will be received, upon request of the Secretary of State, at the port of entry or debarkation upon arrival in the United States from a foreign country and be provided, to the extent necessary, with

temporary care, treatment, and assistance, pending transfer and release or hospitalization pursuant to the Act. The Administrator shall also make suitable arrangements with appropriate divisions of the Public Health Service, with Saint Elizabeths Hospital in the District of Columbia, with Federal hospitals outside of the Department, or with other public or private hospitals to provide the eligible person with care and treatment in a hospital. The Administrator shall maintain a roster setting forth the name and address of each eligible person currently receiving care and treatment, or assistance, pursuant to the Act.

§ 211.3 Certificates.

The following certificates are necessary to establish that an individual is an eligible person:

(a) *Certificates as to nationality.* A certificate issued by an authorized official of the Department of State, stating that the individual is a national of the United States.

(b) *Certificate as to mental condition.* Either (1) a certificate obtained or transmitted by an authorized official of the Department of State that the individual has been legally adjudged insane in a named foreign country; or (2) a certificate of an appropriate authority or person stating that at the time of such certification the individual was in a named foreign country and was in need of care and treatment in a mental hospital. A statement shall, if possible, be incorporated into or attached to the certificate furnished under this paragraph setting forth all available medical and other pertinent information concerning the individual.

(c) *Appropriate authority or person.* For the purpose of paragraph (b)(2) of this section a medical officer of the Public Health Service or of another agency of the United States, or a medical practitioner legally authorized to provide care or treatment of mentally ill persons in the foreign country, is an "appropriate authority or person," and shall be so identified in his execution of the certificate. If such a medical officer or practitioner is unavailable, an authorized official of the Department of State may serve as an "appropriate authority or person and shall, in the execution of the ce tificate, identity himself as serving such person due to the unavailabili of a suitable medical officer or prac tioner.

§ 211.4 Notification to legal guardia spouse, next of kin, or interested p sons.

(a) Whenever an eligible person a rives in the United States from a fc eign country, or when such person transferred from one State to anothe the Administrator shall, upon such a rival or transfer (or in advance ther of, if possible), provide for notificati of his legal guardian, or in the absen of such a guardian, of his spouse next of kin, or in the absence of any these, of one or more interested pe sons, if known.

(b) Whenever an eligible person admitted to a hospital pursuant to tl Act, the Administrator shall provi for immediate notification of his leg guardian, spouse, or next of kin, known.

§ 211.5 Action under State law; appoir ment of guardian.

Whenever an eligible person is i capable of giving his consent to ca and treatment in a hospital, either b cause of his mental condition or b cause he is a minor, the agency w take appropriate action under Sta law, including, if necessary, procuri the appointment of a legal guardia to ensure the proper planning for ar provision of such care and treatment

§ 211.6 Reception; temporary care, tre ment, and assistance.

(a) *Reception.* The agency will me the eligible person at the port of enti or debarkation, will arrange for appr priate medical examination, and w plan with him, in cooperation with h legal guardian, or, in the absence such a guardian, with other interest persons, if any, for needed tempora care and treatment.

(b) *Temporary care, treatment, ar assistance.* The agency will provide f temporary care, treatment, and assis ance, as reasonably required for th health and welfare of the eligib

person. Such care, treatment, and assistance may be provided in the form of hospitalization and other medical and remedial care (including services of necessary attendants), food and lodging, money, payments, transportation, or other goods and services. The agency will utilize the Public Health Service General Hospital nearest to the port of entry or debarkation or any other suitable public or private hospital, in providing hospitalization and medical care, including diagnostic service as needed, pending other appropriate arrangements for serving the eligible person.

§ 211.7 Transfer and release of eligible person.

(a) *Transfer and release to relative.* If at the time of arrival from a foreign country or any time during temporary or continuing care and treatment the Administrator finds that the best interests of the eligible person will be served thereby, and a relative, having been fully informed of his condition, agrees in writing to assume responsibility for his care and treatment, the Administrator shall transfer and release him to such relative. In determining whether his best interest will be served by such transfer and release, due weight shall be given to the relationship of the individuals involved, the financial ability of the relative to provide for such person, and the accessibility to necessary medical facilities.

(b) *Transfer and release to appropriate State authorities, or agency of the United States.* If appropriate arrangements cannot be accomplished under paragraph (a) of this section, and if no other agency of the United States is responsible for the care and treatment of the eligible person, the Administrator shall endeavor to arrange with the appropriate State mental health authorities of the eligible person's State of residence or legal domicile, if any, for the assumption of responsibility for the care and treatment of the eligible person by such authorities and shall, upon the making of such arrangements in writing, transfer and release him to such authorities. If any other agency of the United States is responsible for the care and treatment of the eligible person, the Administrator shall make arrangements for his transfer and release to that agency.

§ 211.8 Continuing hospitalization.

(a) *Authorization and arrangements.* In the event that appropriate arrangements for an eligible person in need of continuing care and treatment in a hospital cannot be accomplished under § 211.7, or until such arrangements can be made, care and treatment shall be provided by the Administrator in Saint Elizabeths Hospital in the District of Columbia, in an appropriate Public Health Service Hospital, or in such other suitable public or private hospital as the Administrator determines is in the best interests of such person.

(b) *Transfer to other hospital.* At any time during continuing hospitalization, when the Administrator deems it to be in the interest of the eligible person or of the hospital affected, the Administrator shall authorize the transfer of such person from one hospital to another and, where necessary to that end, the Administrator shall authorize the initiation of judicial proceedings for the purpose of obtaining a commitment of such person to the Secretary.

(c) *Place of hospitalization.* In determining the placement or transfer of an eligible person for purposes of hospitalization, due weight shall be given to such factors as the location of the eligible person's legal guardian or family, the character of his illness and the probable duration thereof, and the facilities of the hospital to provide care and treatment for the particular health needs of such person.

§ 211.9 Examination and reexamination.

Following admission of an eligible person to a hospital for temporary or continuing care and treatment, he shall be examined by qualified members of the medical staff as soon as practicable, but not later than the fifth day after his admission. Each such person shall be reexamined at least once within each six month period beginning with the month following the month in which he was first examined.

§ 211.10 Termination of hospitalization.

(a) *Discharge or conditional release.* If, following an examination, the head of the hospital finds that the eligible person hospitalized for mental illness (whether or not pursuant to a judicial commitment) is not in need of such hospitalization, he shall be discharged. In the case where hospitalization was pursuant to a judicial commitment, the head of the hospital may, in accordance with laws governing hospitalization for mental illness as may be in force and generally applicable in the State in which the hospital is located, conditionally release him if he finds that this is in his best interests.

(b) *Notification to committing court.* In the case of any person hospitalized under § 211.8 who has been judicially committed to the custody of the Secretary, the Secretary will notify the committing court in writing of the discharge or conditional release of such person under this section or of his transfer and release under § 211.7.

§ 211.11 Request for release from hospitalization.

If an eligible person who is hospitalized pursuant to the Act, or his legal guardian, spouse, or adult next of kin, requests his release, such request shall be granted by the Administrator if his best interests will be served thereby, or by the head of the hospital if he is found not to be in need of hospitalization by reason of mental illness. The right of the administrator or the head of the hospital, to refuse such request and to detain him for care and treatment shall be determined in accordance with laws governing the detention, for care and treatment, of persons alleged to be mentally ill as may be in force and applicable generally in the State in which such hospital is located, but in no event shall the patient be detained more than forty-eight hours (excluding any period of time falling on a Sunday or a legal holiday observed by the courts of the State in which such hospital is located) after the receipt of such request unless within such time (a) judicial proceedings for such hospitalization are commenced or (b) a judicial extension of such time is obtained, for a period of not more than five days, for the c mencement of such proceedings.

§ 211.12 Federal payments.

The arrangements made by the ministrator with an agency or hosp for carrying out the purposes of Act shall provide for payments to s agency or hospital, either in adva or by way of reimbursement, of costs of reception, temporary c treatment, and assistance, continu care and treatment, and transpo tion, pursuant to the Act, and p ments for other expenditures ne sarily and reasonably related to p viding the same. Such arrangeme shall include the methods and pr dures for determining the amount the advances or reimbursements, for remittance and adjustment th of.

§ 211.13 Financial responsibility of the gible person; collections, compron or waiver of payment.

(a) *For temporary care and tr ment.* If an eligible person receiv temporary care, treatment, and ass ance, pursuant to the Act, has fin cial resources available to pay all part of the costs of such care, the ministrator shall require him to for such costs, either in advance or way of reimbursement, unless in judgment it would be inequitable impracticable to require such p ment.

(b) *For continuing care and tr ment.* Any eligible person receiv continuing care and treatment ir hospital, or his estate, shall be lia to pay or contribute toward the p ment of the costs or charges there to the same extent as such per would, if a resident of the District Columbia, be liable to pay, under laws of the District of Columbia, his care and maintenance in a hospi for the mentally ill in that juris tion.

(c) *Collections, compromise, waiver of payment.* The Administra may, in his discretion, where in judgment substantial justice will best served thereby or the probable covery will not warrant the expense collection, compromise, or waive

whole or any portion of, any claim for continuing care and treatment, and assistance, and in the process of arriving at such decision, the Administrator may make or cause to be made such investigations as may be necessary to determine the ability of the patient to pay or contribute toward the cost of his continuing care and treatment in a hospital.

§ 211.14 Disclosure of information.

(a) No disclosure of any information of a personal and private nature with respect to an individual obtained at any time by any person, organization, or institution in the course of discharging the duties of the Secretary under the Act shall be made except insofar:

(1) As the individual or his legal guardian, if any (or, if he is a minor, his parent or legal guardian), shall consent;

(2) As disclosure may be necessary to carry out any functions of the Secretary under the Act;

(3) As disclosure may be directed by the order of a court of competent jurisdiction;

(4) As disclosure may be necessary to carry out any functions of any agency of the United States which are related to the return of the individual from a foreign country, or his entry into the United States; or

(5) As expressly authorized by the Administrator.

(b) An agreement made with an agency or hospital for care, treatment, and assistance pursuant to the Act shall provide that no disclosure will be made of any information of a personal and private nature received by such agency or hospital in the course of discharging the duties under such agreement except as is provided therein, or is otherwise specifically authorized by the Administrator.

(c) Nothing in this section shall preclude disclosure, upon proper inquiry, of information as to the presence of an eligible person in a hospital, or as to his general condition and progress.

§ 211.15 Nondiscrimination.

(a) No eligible person shall, on the ground of race, color, or national origin, be excluded from participation, be denied any benefits, or otherwise be subjected to discrimination of any nature or form in the provision of any benefits, under the Act.

(b) The prohibition in paragraph (a) of this section precludes discrimination either in the selection of individuals to receive the benefits, in the scope of benefits, or in the manner of providing them. It extends to all facilities and services provided by the Administrator or an agency to an individual, and to the arrangements and the procedures under this part relating thereto, in connection with reception, temporary care, treatment, and assistance, and continuing hospitalization under the Act.

PART 212—ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES

Sec.

AUTHORITY: Sec. 302, 75 Stat. 142, sec. 1102, 49 Stat. 647; 42 U.S.C. 1313, 1302.

SOURCE: 39 FR 26548, July 19, 1974, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to this part appear at 53 FR 36580, Sept. 21, 1988.

§ 212.1 General definitions.

When used in this part:

(a) *Act* means section 1113 of the Social Security Act, as amended;

(b) The term *Secretary* means the Secretary of Health and Human Services;

(c) The term *Department* means the Department of Health and Human Services;

(d) The term *Administration* means the Family Support Administration, Department of Health and Human Services;

(e) The term *Administrator* means the Administrator, Family Support Administration;

(f) The term *eligible person* means an individual with respect to whom the conditions in § 212.3 are met;

(g) The term *State* includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

(h) The term *United States* when used in a geographical sense means the States;

(i) The term *agency* means State or local public agency or organization or national or local private agency or organization with which the Administrator has entered into agreement for the provision of temporary assistance pursuant to the Act;

(j) The term *temporary assistance* means money payments, medical care, temporary billeting, transportation, and other goods and services necessary for the health, or welfare of individuals, including guidance, counseling, and other welfare services.

[39 FR 26548, July 19, 1974, as amended at 53 FR 36580, Sept. 21, 1988]

§ 212.2 General.

The Administrator shall develop plans and make arrangements for provision of temporary assistance within the United States to any eligible person, after consultation with appropriate offices of the Department of State, the Department of Justice, and the Department of Defense. Temporary assistance shall be provided, to the extent feasible, in accordance with such plans, as modified from time to time by the Administrator. The Administrator shall enter into agreements with agencies whose services and facilities are to be utilized for the purpose of providing temporary assistance pursuant to the Act, specifying the conditions governing the provision of such assistance and the manner of payment of the cost of providing therefor.

§ 212.3 Eligible person.

In order to establish that an individual is an eligible person, it must be found that:

(a) He is a citizen of the Ur States or a dependent of a citize the United States;

(b) A written statement has transmitted to the Service by an thorized official of the Departmer State containing information w identifies him as having returnec been brought, from a foreign cou to the United States because of destitution of the citizen of the Ur States, or the illness of such citize any of his dependents, or becaus war, threat of war, invasion, or sin crisis. Such statement shall, if p ble, incorporate or have atta thereto, all available pertinent ir mation concerning the individual case of war, threat of war, invasio similar crisis, a determination by Department of State that such a dition is the general cause for return of citizens of the United St and their dependents from a par lar foreign country, and evidence an individual has returned, or, l brought, from such country to United States shall be considered ficient identification of the reasor his return to, or entry into the Ur States; and

(c) He is without resources imr ately accessible to meet his needs.

§ 212.4 Reception; initial determina provisions of temporary assistance

(a) The Administration, or agency upon notification by the ministration, will meet individ identified as provided in § 212.3(b the port of entry or debarkation.

(b) The Administration or age will make findings, setting forth pertinent facts and conclusions, an initial determination, accordin standards established by the Adm tration, as to whether an individu an eligible person.

(c) The Administration or age will provide temporary assista within the United States to an elig person, according to standards of r established by the Administrat upon arrival at the port of entry or barkation, during transportation to intermediate and ultimate dest tions, and after arrival at such dest tions.

PROGRAM STANDARDS - F MEDICAID
Age of a Child

305-2 Age of a child

This applies to applicants as well as recipients.

1. A child must be under age 18 years. A child is eligible for the month of the 18th birthday.

2. Some 18-year-olds can continue to receive F or C Medicaid if the 18-year-old meets all 3 of the following conditions:

   A. The 18-year-old is a full time student.
   AND
   B. Participates in a program of secondary school or equivalent level of vocational or technical training.
   AND
   C. Reasonably expects to complete that educational program before reaching age 19 years.

3. An 18-year-old full-time student who expects to complete that program before reaching age 19 is eligible until completion of the school program.

   EXAMPLE:
   Marty is an 18-year-old high school student. He will graduate from high school in May. He does not turn 19 until October. Marty is eligible until the end of May.

4. An 18-year-old high school student who will reach age 19 before completion of the school program is ineligible the month following the month of his 18th birthday.

   EXAMPLE:
   Joan is an 18-year-old high school student. She will graduate in June 1988. She turns 19 in April 1988. Joan is only eligible through the end of the month in which she turns 18, April 1987.

305-3 Specified Relatives

1. Eligible Adults

An adult may be eligible for F Medicaid if that adult is a specified relative for a child living in the same home.

2. Eligible Children

Children may be eligible for F Medicaid if they live in the same home with a specified relative.

3. Who Are Specified Relatives?

Here are some **examples** of specified relatives:

A. Parents (See Section 229)

B. Grandparents

C. Brother or Sister, including step-brothers and step-sisters, half-brothers and half-sisters, and adopted brothers and sisters

D. Aunt or Uncle

E. First Cousin

F. Nephew or Niece

G. People of prior generations as designated by the prefix grand, great or great-great

H. The spouse of any person on this list (See Section 229-3 for information on Common-law Marriage)

(Continued on next page)

l. The former spouse of any person on this list

4. Temporary Absences

Count adults or children as living with each other during temporary absences from the home. This includes absences for schooling, visits, and medical treatment. Indian children in boarding schools are temporarily absent from their home. Children in a school for the deaf and blind are temporarily absent from their home.

similar programs, unless determined by the Director of the Action Agency to constitute the minimum wage, under sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973 (87 Stat. 409, 413) as amended by Pub L No 96-143, (93 Stat 1077), 42 U S C 5044(g) and 5058)

NOTE—This exclusion does not apply to the income of sponsors of aliens

(b) Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub L 95-478 (92 Stat 1515, 42 U S C 3020a)

[45 FR 65547, Oct 3, 1980, as amended at 52 FR 8888, Mar 20, 1987]

Subpart L—Resources and Exclusions

AUTHORITY Secs 1102, 1602, 1611, 1612, 1613, 1614(f), 1621, and 1631 of the Social Security Act, 42 U S C 1302, 1381a, 1382, 1382a, 1382b, 1382c(f) 1382j, and 1383 sec 211 of Pub L 93-66, 87 Stat 154

SOURCE 40 FR 48915, Oct 20, 1975, unless otherwise noted

§ 416.1201 Resources; general.

(a) *Resources, defined.* For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)

(2) Support and maintenance assistance not counted as income under § 416 1157(c) will not be considered a resource.

(3) Except for cash reimbursement of medical or social services expenses already paid for by the individual, cash received for medical or social services that is ,not income under § 416 1103 (a) or (b) is not a resource for the calendar month following the month of its receipt However, cash retained until the first moment of the second calendar month following its receipt is a resource at that time.

(4) Death benefits, including gifts and inheritances, received by an individual, to the extent that they are not income in accordance with paragraphs (e) and (g) of § 416.1121 because they are to be spent on costs resulting from the last illness and burial of the deceased, are not resources for the calendar month following the month of receipt. However, such death benefits retained until the first moment of the second calendar month following their receipt are resources at that time.

(b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in § 416 120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, bank accounts (savings and checking), certificates of deposit and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources.

(c) *Nonliquid resources.* (1) Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days excluding certain nonwork days as explained in § 416 120(d) Examples of resources that are ordinarily nonliquid are loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Nonliquid resources are evaluated according to their equity value except as otherwise provided. (See § 416.1218 for treatment of automobiles.)

(2) For purposes of this subpart L, the *equity value* of an item is defined as.

(i) The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus

(ii) Any encumbrances.

[40 FR 48915 Oct 20 1975 as amended at 44 FR 43266, July 24 1979 48 FR 33259 July 21, 1983, 52 FR 4283 Feb 11, 1987, 52 FR 16845 May 6, 1987, 53 FR 23231, June 21, 1988, 56 FR 36001, July 30 1991]

§ 416.1202 Deeming of resources.

(a) *Married individual.* In the case of an individual who is living with a person not eligible under this part and who is considered to be the husband or wife of such individual under the criteria in §§ 416 1806 and 416.1811,

the month. A resource determina-
n is based on what assets an individ-
l has, what their values are, and
ıether or not they are excluded as of
e first moment of the month.

b) *Increase in value of resources.* If,
ring a month, a resource increases
value or an individual acquires an
ditional resource or replaces an ex-
ıded resource with one that is not
cluded, the increase in the value of
e resources is counted as of the first
ɔment of the next month

c) *Decrease in value of resources.* If,
ring a month, a resource decreases
value or an individual spends a re-
urce or replaces a resource that is
t excluded with one that is ex-
ıded, the decrease in the value of
e resources is counted as of the first
ɔment of the next month.

(d) *Treatment of items under income
ıd resource counting rules.* Items re-
ived in cash or in kind during a
ɔnth are evaluated first under the
come counting rules and, if retained
ıtil the first moment of the follow-
g month, are subject to the rules for
unting resources at that time.

(e) *Receipts from the sale, exchange,
replacement of a resource.* If an in-
vidual sells, exchanges or replaces a
source, the receipts are not income.
ıey are still considered to be a re-
urce. This rule includes resources
at have never been counted as such
cause they were sold, exchanged or
placed in the month in which they
ere received. See § 416.1246 for the
le on resources disposed of for less
an fair market value (including
ose disposed of during the month of
ceipt).

Example: Miss L., a disabled individual, re-
ives a $350 unemployment insurance ben-
t on January 10, 1986. The benefit is un-
rned income to Miss L. when she receives
On January 14, Miss L. uses the $350 pay-
ent to purchase shares of stock. Miss L.
s exchanged one item (cash) for another
m (stock). The $350 payment is never
unted as a resource to Miss L. because she
changed it in the same month she re-
ived it. The stock is not income; it is a dif-
rent form of a resource exchanged for the
sh. Since a resource is not countable until
e first moment of the month following its
ceipt, the stock is not a countable re-
urce to Miss L. until February 1.

[2 FR 4283, Feb. 11, 1987]

§ 416.1210 Exclusions from resources; general.

In determining the resources of an individual (and spouse, if any) the following items shall be excluded:

(a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in § 416.1212;

(b) Household goods and personal effects to the extent that their total value does not exceed the amount provided in § 416.1216;

(c) An automobile to the extent that its value does not exceed the amount provided in § 416.1218;

(d) Property of a trade or business which is essential to the means of self-support as provided in § 416.1222;

(e) Nonbusiness property which is essential to the means of self-support as provided in § 416.1224;

(f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in § 416.1226;

(g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see § 416.1228);

(h) Life insurance owned by an individual (and spouse, if any) to the extent provided in § 416.1230; and

(i) Restricted allotted land owned by an enrolled member of an Indian tribe as provided in § 416.1234;

(j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute;

(k) Disaster relief assistance as provided in § 416.1237;

(l) Burial spaces and certain funds up to $1,500 for burial expenses as provided in § 416.1231.

(m) Title XVI or title II retroactive payments as provided in § 416.1233.

(n) Housing assistance as provided in § 416.1238.

[40 FR 48915, Oct. 20, 1975, as amended at 41 FR 13338, Mar. 30, 1976; 44 FR 15664, Mar. 15, 1979; 48 FR 57127, Dec. 28, 1983; 51 FR 34464, Sept. 29, 1986; 55 FR 28378, July 11, 1990]

LEGISLATIVE HISTORY

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and over 246,000 aged were aided in March 1965. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs."

Under the House bill, after an interim period ending June 30, 1967, all States would have to adopt the new program or lose Federal matching as to vendor medical payments since the current provisions of law would expire at that time. Under the committee bill the States will have the option of participating under the new program or continuing to operate under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program). Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(b) State plan requirements

(1) Standard provisions

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, the committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that, effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, the committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

The committee's bill would add a requirement that the State plan include a description of the standards, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance. This amendment would give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods. In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new title XIX, requiring States to have an authority or authorities responsible for establish-

ing and maintaining standards for private or public institutions in which recipients may receive care or services.

The committee also added an amendment to require that, after June 30, 1967, private and public medical institutions must meet standards (which may be in addition to the standards prescribed by the State) relating to protection against fire and other hazards to the health and safety of individuals, which are established by the Secretary of Health, Education, and Welfare. The committee assumes that the standards prescribed by many States at the present time will meet or exceed those prescribed by the Secretary.

The House bill provided that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State supervised, the same State agency shall supervise the administration of title XIX.

The committee believes that the States should be given the opportunity to select the agency they wish to administer the program. A number of witnesses appearing before the committee have expressed the belief that the State health agency should be given the primary responsibility under this program. The committee bill leaves this decision wholly to the States with the sole requirement that the determination of eligibility for medical assistance be made by the State or local agency administering State plans approved under title I or XVI. The committee agrees with the statement in the House report that the welfare agencies have "long experience and skill in determination of eligibility."

The committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the new program, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individuals. This would include the eligibility determining function. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is hoped that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of the committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of ad-

BASIC RULES - RESIDENTS OF INSTITUTIONS
What is an Institution?

215 Residents of Institutions

Residents of certain institutions are not eligible for Medicaid. Residents of other institutions may be eligible for Medicaid. If so, follow the rules in Volume III-M for the months in which the client must be considered a resident of a medical institution.

Residents of households are eligible for Medicaid if all other factors of eligibility are met.

215-1 What is an Institution?

Medicaid policy defines all dwellings as either a household or an institution. When determining Medicaid eligibility, it is important to decide if the place a person lives is a household or an institution.

To be an institution, all the following criteria must be met.

1. It has an owner, a manager, or other person in charge

2. It provides food, shelter, and some treatment or service to its residents.

3. It is designed to provide for four or more people who are not related to the owner (there may be less than four people living there).
   OR
   It is providing for four or more people who are not related to the proprietor.

89th Congress, 1st Session House Report No. 213

SOCIAL SECURITY AMENDMENTS OF 1965

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 6675

TO PROVIDE A HOSPITAL INSURANCE PROGRAM FOR THE AGED UNDER THE SOCIAL SECURITY ACT WITH A SUPPLEMENTARY HEALTH BENEFITS PROGRAM AND AN EXPANDED PROGRAM OF MEDICAL ASSISTANCE, TO INCREASE BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO IMPROVE THE FEDERAL-STATE PUBLIC ASSISTANCE PROGRAM, AND FOR OTHER PURPOSES

MARCH 29, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
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89TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { 213

SOCIAL SECURITY AMENDMENTS OF 1965

MARCH 29, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 6675]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

uals. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of your committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. Your committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

(*c*) *Eligibility fo medical assistance*

Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to the less needy than those who would be eligible for aid under the various other categories of public assistance.

Under your committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various categories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

(*d*) *Determination of need for medical assistance*

Your committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual. The provisions also are designed to assure that whatever is applicable under titles I, IV, X, XIV, and XVI for the disregarding of income or for setting aside of income shall also be applicable in evaluating the income of the individual who is applying for medical assistance under title XIX. Titles I and X now

that income may be set aside for the future needs of the children. Other pertinent provisions for the disregard of income are found in the Economic Opportunity Act and the Food Stamp Act of 1964.

Your committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, your committee bill requires that the States standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost whether in the form of insurance premiums or otherwise incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be $2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than $2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or

nor of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. Your committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, your committee's bill provides that the States make provisions, for individuals 65 years or older, of the cost of any deductible imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his

mittee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) Scope and definition of medical services

"Medical assistance" is defined under the bill to mean payment of all or part of the care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

Your committee bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

Inpatient hospital services.
Outpatient hospital services
Other laboratory and X-ray services.
Skilled nursing home services.
Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

In the opinion of your committee, these are the most essential items of service which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in titles I and XVI—for some institutional and some noninstitutional services.

Other items of medical service which the States may, if they wish include in their plans are:

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
Home health care services.
Clinic service.
Private duty nursing service.
Dental service.
Physical therapy and related services.
Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.
Other diagnostic, screening, preventive, and rehabilitative services.
Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The States must pay the reasonable cost of inpatient hospital service for the number of days of care provided under the plan.

Among the items of medical services which the States may include is medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Under this provision, a State may if it wishes, include medical and remedial services provided by osteopaths, chiropractors, optometrists and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

If a State chooses to provide eyeglasses as a service under the plan your committee believes that the individual recipient should be free to select either a physician skilled in diseases of the eye or an optometrist to provide these glasses. Many small communities do not have qualified ophthalmologists but do have optometrists who are competent to provide, fit, or change eyeglasses.

In addition to the items specifically listed, the Secretary is authorized to define any other medical care or any other type of remedial care recognized under State law which he believes might be provided by the States and in which the Federal Government will participate financially.

The State plan may not include any individual who is an inmate of a public institution, except as a patient in a medical institution; nor may it include any individual under the age of 65 who is a patient in an institution for tuberculosis or mental diseases.

Under title XIX, it will be possible for States to give medical assistance to persons 65 years of age and older who are in mental and tuberculosis institutions and to otherwise eligible persons of any age with a diagnosis of psychosis or tuberculosis and who are receiving care in other medical institutions. Under the bill, if the plan includes medical assistance for patients in institutions for mental diseases or tuberculosis, various requirements are specified for inclusion in the State plan with respect to these individuals and various other fiscal and other provisions are included. These are identical with those included in title II, part 3 of the bill and are explained elsewhere in this report.

Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance, e.g., by attaining a specified age. This avoids the administrative inconvenience of having to segregate bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles.

(f) Other conditions for plan approval

Title XIX requires that the Secretary approve any plan which fulfills the plan requirements specified and described above and which does not contain certain other conditions. Under these provisions, a State plan may not include an age requirement of more than 65 years. Effective July 1, 1967, States may not, under the provisions of your committee bill, exclude any individual who has not attained the age of 21 and is, or would, except for the provisions of section 406(a)(2) be a dependent child under title IV. Thus,